New Jersey Department of Health and Senior Services
Office of Home and Community Services
Adult Day Services Program for Persons with Alzheimer's Disease or Related Disorders
PO Box 807
Trenton, NJ 08625-0807

CLIENT DEMOGRAPHIC DATA

Client Name	Agency Name

1. Source of Client Referral (Check one) (1) ____ ____
   - 00☐ Self
   - 01☐ Family
   - 02☐ Professionals
   - 03☐ Long Term Care Facility
   - 04☐ Home Care Agency
   - 05☐ Hospital Provider
   - 06☐ Adult Day Care Center
   - 07☐ Social Service Agency
   - 08☐ Community Support Group
   - 99☐ Other _____

2. Sex 00☐ Male 01☐ Female (2) ____ ____

3. Client's Date of Birth
   - a. Month ____ ____ (3a) ____ ____
   - b. Year ____ ____ (3b) ____ ____
   - c. Age ____ ____ (3c) ____ ____

4. Client's Primary Diagnosis (dementia) (4) ____ ____
   - 00☐ Alzheimer's Disease
   - 01☐ Multi-Infarct Dementia
   - 02☐ Parkinson's Disease
   - 03☐ Huntington's Disease
   - 04☐ Creutzfeldt-Jakob Disease
   - 05☐ Pick's Disease
   - 99☐ Other _____

5. Source of Above Diagnosis (5) ____ ____
   - 00☐ Family Physician/ General Practitioner
   - 01☐ Neurologist
   - 02☐ Psychiatrist
   - 03☐ Geriatric Assessment Center
   - 04☐ Alzheimer's Assessment Center
   - 05☐ Medical Clinic
   - 99☐ Other _____

6. When Was Diagnosis Made?
   - a. Month ____ ____ (6a) ____ ____
   - b. Year ____ ____ (6b) ____ ____

7. Client's Current Residence
   - a. County ____ ____ (7a) ____ ____
   - b. State ____ ____ (7b) ____ ____

8. Client's Ethnicity/Race (8) ____ ____
   - 00☐ African American
   - 01☐ Hispanic
   - 02☐ Asian/Pacific Islander
   - 03☐ American Indian/Alaskan Native
   - 04☐ Non-Minority

9. Client's Current Marital/Relationship Status (9) ____ ____
   - 00☐ Never Married
   - 01☐ Married
   - 02☐ Widowed
   - 03☐ Divorced
   - 04☐ Separated
   - 05☐ Living Together

10. Client's Present Living Arrangements (10) ____ ____
    - 00☐ Living Alone
    - 01☐ Living in a household with spouse only
    - 02☐ Living in a household with others related
    - 03☐ Living in a household with others unrelated
    - 99☐ Other (Specify) _____

11. Client's Residence (11) ____ ____
    - 00☐ Adult Community
    - 01☐ House
    - 02☐ Condominium
    - 03☐ Apartment
    - 04☐ Room: Hotel
    - 05☐ Mobile Home
    - 08☐ Senior Housing
    - 99☐ Other/No Response _____

CLIENT DEMOGRAPHIC DATA

Client Name

Agency Name

12. Does Client Rent or Own Present Residence?
00☐Rent 01☐Own 97☐N/A (12) ____ ____

13. Current Combined Annual Income of Client or Client and Spouse (or Spouse Equivalent)
00☐Under $4,999 03☐$15,000 - 19,999 (13) ____ ____
01☐$5,000 - 9,999 04☐$20,000 - 29,999
02☐$10,000 - 14,999 05☐$30,000 and Above

14. Client's General Health Care Payment Mechanism(s) (Check up to 3)
00☐]Medicare Part A 04☐Health Maintenance Organization (14) ____ ____
01☐Medicare Part B 05☐Veterans Administration
02☐Medicaid 99☐Other Health Insurance ____ ____
03☐Private Pay
____ ____

15. Client's Employment Status (check up to 2)
00☐Worked FT 03☐Disabled (15) ____ ____
01☐Worked PT 04☐Never Worked
02☐Retired ____ ____

16. Client's Ability to Perform Self-Care
00☐Independent (16) ____ ____
01☐Independent, W/Minimal Assistance
02☐Independent, W/Moderate Assistance
03☐Independent, W/Maximum Assistance
04☐Dependent

17. Client's Primary Caretaker
00☐Spouse 04☐Friend/Neighbor (17) ____ ____
01☐Son 05☐Volunteer
02☐Daughter 99☐Other _____
03☐Other Relative(s)

18. Primary Caretaker's Employment Status (check up to 2)
00☐Working FT 03☐Disabled 99☐Other (18) ____ ____
01☐Working PT 04☐Never Worked
02☐Retired 05☐Unemployed _____ ____ ____

19. Client's Service Utilization in the Past Six (6) Months (Check no more than 5)
00☐Primary Care or Other Physician 07☐Adult Day Care Services (19) ____ ____
01☐Hospital 08☐Transportation Services
02☐Community Support Group 09☐Medical Clinic ____ ____
03☐Senior Center Services 10☐Psychiatric Clinic
04☐Congregate/Home Delivered Meals 11☐Boarding Home ____ ____
05☐Home Health Care Services 12☐LTC Facility
06☐Homemaker/Chore Services 13☐No Service Utilization ____ ____
____ ____

20. Has Client Been in a Hospital Overnight or Longer in the Last Twelve (12) Months?
00☐Yes 01☐No (20) ____ ____
a. If Yes, Number of Admissions:
00☐1-3 01☐4-6 02☐7 and Above (20a) ____ ____

21. Does Client Currently Have a Regular Physician/Established Health Care Source?
00☐Yes 01☐No (21) ____ ____

22. Client's Other Diagnoses/Problems (List no more than 5; rank in order of importance.)

00☐	____	Anemia	11☐	____	Osteoporosis	(22) ____ ____	1st
01☐	____	Arthritis	12☐	____	Speech Impairment		
02☐	____	Cancer	13☐	____	Stroke	____ ____	2nd
04☐	____	Diabetes	14☐	____	Tuberculosis		
05☐	____	COPD	15☐	____	Visual Impairment	____ ____	3rd
06☐	____	Genito-Urinary Problems	16☐	____	Gastrointestinal Disorder		
07☐	____	Hearing Impairment	17☐	____	Vascular Disorder	____ ____	4th
08☐	____	Heart Disease	18☐	____	Seizure Disorder		
09☐	____	Hypertension	19☐	____	Musculoskeletal Disorder	____ ____	5th
10☐	____	Hypothyroidism	99☐	____	Other _____		

CLIENT DEMOGRAPHIC DATA

Client Name

Agency Name

23. Initial Date of Entry into Adult Day Care Program

a. Month _____ _____ (23a) _____ _____

b. Day _____ _____ (23b) _____ _____

c. Year _____ _____ (23c) _____ _____

24. Number of Days Per Week of Attendance in Adult Day Care Program
01☐1 02☐2 03☐3 04☐4 05☐5 06☐6 07☐7 (24) _____ _____

25. Sources of Payment for Client's Day Care, Excluding Copay (Check all applicable)
00☐Self 06☐Peer Grouping (25) _____ _____
01☐Family 07☐Alzheimer's Funding (DHSS)
02☐Medicaid 08☐Statewide Respite _____ _____
03☐CCPED 09☐JACC
04☐Older Americans Act 10☐CAP _____ _____
05☐SSBG 99☐Other _____ _____ _____

26. Number of Days of Care/Week to be Provided by DHSS - Alzheimer's Adult Day Services Program
00☐1 01☐2 02☐3 03☐4 04☐5 (26) _____ _____

27. Will Client make a Co-Payment?
00☐No 01☐Yes (27) _____ _____

28. Reasons for Attendance (Check up to 4 and rank in order of importance)
00☐ _____ Requires Supervision During the Day (28) _____ _____ 1st
01☐ _____ Respite for Caregiver
02☐ _____ Social Isolation _____ _____ 2nd
03☐ _____ Caregiver's Employment
04☐ _____ Deterioration of ADL _____ _____ 3rd
05☐ _____ Loss of Primary Caregiver
99☐ _____ Other _____ _____ _____ 4th

29. Client's Pattern of Elimination (Check 2)
00☐Total Bladder Control 03☐Requires Assistance-Bowel (29) _____ _____
01☐Total Bowel Control 04☐Absence of Bladder Control
02☐Requires Assistance-Bladder 05☐Absence of Bowel Control _____ _____

30. Client's Mobility Status
00☐Self Ambulatory 03☐Non-Ambulatory Wheelchair (30) _____ _____
01☐Ambulatory with Assistance 04☐Uses Wheelchair-Distance Only
02☐Ambulatory with Walker 99☐Other _____ _____ _____

31. Actions to be Taken During Program Attendance to Deal With Client's Problems
(Check no more than 5; rank those five in order of importance.)
00☐ _____ Counseling (31) _____ _____ 1st
01☐ _____ Therapeutic Exercise
02☐ _____ Personal Care _____ _____ 2nd
03☐ _____ Socialization
04☐ _____ Activity Programming _____ _____ 3rd
05☐ _____ Bowel/Bladder Training
06☐ _____ Cognitive Stimulation _____ _____ 4th
07☐ _____ Health Monitoring
99☐ _____ Other _____ _____ _____ 5th

32. Actions to be Taken to Deal with Family's Current Problems
(Check up to 3 and rank those 3 in order of importance)
00☐ _____ Mental Health Services 05☐ _____ Medical Assistance (32) _____ _____ 1st
01☐ _____ Community Support Groups 06☐ _____ Substance Abuse Treatment
02☐ _____ Respite Care 07☐ _____ Marital/Family Counseling _____ _____ 2nd
03☐ _____ Legal Services 08☐ _____ Geriatric Assessment Center
04☐ _____ Financial Assistance 09☐ _____ None _____ _____ 3rd